UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

VENTAVIS (iloprost inhalation solution)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Documented WHO group I NYHA class III or IV pulmonary arterial hypertension
- Documented failure on Flolan **and** Remodulin **and** Revatio **and** Tracleer
- Not for simultaneous use with Flolan, Remodulin, Revatio, or Tracleer
- Submit copy of prescription from physician

INFORMATION:

Medicaid pays for the medication *only* - the patient must make other arrangements for the pump.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone call from physician office or pharmacy

7/19/6